

University of Maryland
Center for Assisted Reproductive Technologies
Egg Donation Program

**Egg Donor Questionnaire – Fax the completed
questionnaire to Donna Ketchum at 410-328-0834.**

General Information:

Name _____ **Date of Birth** _____

Place of Birth _____
City State Country

Social Security Number: _____

Driver's License Number: _____

Current Address _____

Phone
Home: _____ **May we contact you at home:** yes / no
Work: _____ **May we contact you at work:** yes / no
Cell: _____ **May we contact you on your cell:** yes / no

What is the number that you are available during the day? _____
Must be available to be contacted during the day

Email _____

Emergency

Contact Person Phone Number

Health Insurance Policy Number

I heard about the University of Maryland's donor egg program from:

If I am accepted as an egg donor, I would be available to be a donor starting:
____/____/____

Comments: _____

Please attach to the questionnaire a current photograph of you and a copy of your insurance card.

Your identity will be kept confidential. *

Educational and Occupational Information

Did you receive a high school diploma? Yes / No

If you did not receive a high school diploma did you get your GED? Yes / No

Did you attend College or a Trade School? Yes / No

_____ Currently Enrolled Major _____

_____ Graduated Year _____ Degree _____

_____ Graduate/Professional Degree/Field _____

_____ Other: _____

I am currently a full-time student: Yes / No

Are you currently employed? Yes / No

If yes, _____ Full time or _____ Part time

Occupation _____

Religious Association: _____

Comments: _____

Legal Information:

Have you ever been arrested or convicted of any crime (other than minor traffic offenses): Yes / No

If yes explain: _____

Have you ever been involved in a lawsuit: Yes / No

If yes explain: _____

Have you been an inmate of a correctional facility for 72 hours or longer within the past 12 months? Yes / No

Personal and Reproductive History:

Age: _____ Height: _____ Weight: _____

Heritage/Nationality: _____

Eye Color: _____ Hair Color: _____

Hair type (curly, wavy, straight): _____

Complexion: _____ Frame size: _____

Blood Type (if known): _____

Menstrual History:

Age when you had your first period: _____

My menstrual bleeding starts every _____ days and lasts for _____ days.

I sometimes have bleeding between my normal periods: yes / no

I sometimes have bleeding after intercourse: yes / no

I have used oral contraceptives in the past (check all that apply):

___ because my periods are/were very irregular

___ because without them I bleed heavily

___ because without them I have severe pain during my period

___ to prevent pregnancy

___ other: _____

Contraceptive History: (check all that applies)

___ Oral contraceptives

___ Diaphragm

___ Intrauterine Device (IUD)

___ Condoms

___ Progesterone injections (Depo-Provera); Date of last shot: ___/___/___

___ Contraceptive patch

___ Other: _____

I am currently using _____ to prevent pregnancy.

Marital Status:

Single with one current partner Engaged
 Single and dating Married
 Living together Separated
 Divorced

My current relationship is monogamous? Yes / No

Sexual Orientation and History:

I consider myself:

heterosexual homosexual bisexual

1. I have had a homosexual relationship in the past 12 months: yes / no
2. I had sexual activity with a male partner that engaged in homosexual or bisexual behavior in the past 5 years. yes / no
3. Within the past 12 months have or did have a sexual partner that was suspected of having or diagnosed with hepatitis. yes / no
4. In the past 12 months, I have had _____ sexual partners.
5. In the past 12 months, I have or had a sexual partner who has or was suspected of having AIDS/HIV. yes / no
6. In the past 12 months I had intercourse without the use of a condom. yes / no
7. I have had sex in exchange for money or drugs in the past 5 years. yes / no
8. In the past 12 months, I have had sex with a partner that had one or more of the following: Circle all that applies.

Chlamydia	Venereal Warts	Herpes	Trichomonas
Ureaplasma	Syphilis	Gonorrhea	AIDS/HIV
Hepatitis	Non-specific urethritis		

9. I have/had a sexual partner in the last 5 years that used illegal drugs. yes / no

If yes, explain:

10. I have/had been diagnosed with: (circle all that applies)

Chlamydia	Venereal Warts	Herpes	Trichomonas
Ureaplasma	Syphilis	Gonorrhea	AIDS/HIV
Hepatitis	Abnormal Pap	Ovarian Cysts	Endometriosis
Pelvic Inflammatory Disease			

If you have circled any of the above please indicate the date of diagnosis, treatment, and outcome:

Pregnancy History

(check all that applies)

- I have never been pregnant.
- I have never tried to become pregnant.
- I have tried to become pregnant in the past but was not successful.
- I have rarely used birth control in the past but have not become pregnant.
- I have been pregnant before.
- I never had difficulty becoming pregnant.
- I have had difficulty in becoming pregnant at least once in my life.

Pregnancy Outcomes:

Pregnancy	Did you deliver (Type of delivery)	Boy or Girl/Current Age	Does the child have any medical problems	If no delivery, how did the pregnancy terminate? (miscarriage, abortion, etc.)
#1				
#2				
#3				

Medical/ Social History:

1. What childhood illness have you had?

2. I have been to an emergency room or admitted to the hospital? yes / no (if yes, explain)

3. Are you currently under the care of a physician? yes / no (if yes, explain)

4. Do you currently take any medications? yes / no (if yes, explain)

5. Do you have any allergies? yes / no (if yes, explain)

6. Do you have any physical handicaps or limitations? yes / no (if yes, explain)

7. Do you wear contact lenses or glasses? yes / no

If yes, to correct what condition? _____

When did you start wearing them? _____

Do you have a strong prescription? _____

8. Have you ever received a blood transfusion or blood product such as clotting factors or platelets? yes/ no
If yes, when and when? And explain.

9. Have you ever been refused as a blood donor? yes / no *(if yes, explain)*

10. Have you recently been vaccinated or immunized for any reason? yes / no *(if yes, explain)*

11. Have you traveled outside the United States in the past 3 years? yes / no **When? Where?**

12. Have you ever received pituitary – derived human growth hormone? yes / no

13. In the last twelve months, have you had a tattoo, ear/body piercing or acupuncture? yes / no *(if yes, explain)*

14. Have you applied or been screened as an egg donor before? yes / no *(if yes, list the dates of donation, and locations of the program(s))*

15. Were ever rejected as an egg donor? yes / no *(if yes, explain)*

16. Have you been exposed within the past 12 months to known or suspected HIV, hepatitis B, and/or hepatitis C infected blood through percutaneous inoculation (ex. needle stick) or through contact with an open wound, non-intact skin, or mucous membrane? yes / no *(if yes, explain)*

17. Do you have a diagnosis of Creutzfeldt-Jakob disease (Mad Cow disease) or known family history (blood relative) of a person with Creutzfeldt-Jakob Disease? yes / no *(if yes, explain)*

18. Have you received an injection of bovine (beef) insulin made from cattle in the United Kingdom after 1979? yes / no *(if yes, explain)*

19. Have you since 1980, lived in the United Kingdom for a total time that adds up to 3 months, or lived in Europe for a total time that adds up to 6 months? yes / no *(if yes, explain)*

20. In the last 5 years, have you injected drugs in yourself for non- medical reasons? yes / no *(if yes, explain)*

21. Have you ever received transplants of human tissue including dura mater or cornea? yes / no *(if yes, explain)*

22. Do you have a history of dementia or degenerative neuralgic disorders of viral or unknown etiology? yes / no *(if yes, explain)*

23. Have you had any personal experience with a traumatic event? yes / no *(if yes, explain)*

24. Have you received a bite from an animal suspected of carrying rabies within the preceding 12 months? yes / no *(if yes, explain)*

For the following check the appropriate response.

Cigarettes/Tobacco Use:

_____ I never smoked.

_____ I use chewing tobacco.

_____ I smoked in the past.

_____ I currently smoke.

Alcohol Use:

_____ I never drink alcohol.

_____ I have a drink once a month or less.

_____ I have a drink 1-3 times a week.

_____ I have a drink 1-2 times a day.

Drug Use:

_____ I have never used drugs.

_____ I have used drugs at least once in the past, but I don't any more. (How long ago, and how often?)

_____ I have used drugs regularly, but I don't any more. (How long ago, and how often?)

_____ I currently use drugs.

These are the drugs that I have used in the past: (check all that applies)

_____ Marijuana _____ Cocaine _____ Heroin _____ LSD

_____ Barbiturates _____ Amphetamines

_____ Other: _____

These are the drugs that I am using now: (check all that applies)

_____ Marijuana _____ Cocaine _____ Heroin _____ LSD

_____ Barbiturates _____ Amphetamines

_____ Other: _____

Have you ever misused a prescription medication? yes / no (if yes, explain)

Additional Information: (not optional)

I am interested in becoming an egg donor because:

What do you think is your best physical quality? (examples: crystal blue eyes, curly hair)

What do you like least about yourself? (examples: your temper, your body type)

What do you like best about yourself? (examples: your hair, your sense of humor)

What is your best intellectual quality? (examples: mathematics, photographic memory)

What hobbies or pastimes do you particularly enjoy?

Describe your childhood and family life.

Describe one of your favorite childhood memories.

What are your special talents?

Do you have any particular athletic abilities?

What is your goal in life?

What psychological benefit do you expect to get out of the donor experience?

Is there any financial stress contributing to your motivation to donate?

Do reproductive losses in your history contribute to your motivation?

Who have you told about your decision to donate? What was their response?

Will you have someone to help you with injections and reorganizing time to make the appointments. Will you have someone to go with you on the day of the retrieval?

Are you prepared to abstain from unprotected intercourse? You will need to use a condom during your treatment.

Do you have any family history or personal history of depression, anxiety or chemical dependency?

How do you deal with stress?

Is there anything else you feel we should know about your background?

Genetic History

Are you or have you been exposed to toxic chemicals? YES NO

Explain: _____

Are you or have you been exposed to radiation? YES NO

Explain: _____

Has any member of your family had one or more children with birth defects? YES NO

Which relative? _____

Describe the defect: _____

Has any female member of your family had an excessive number of

Spontaneous miscarriages? YES NO

Which relative? _____

If known, cause of the miscarriages: _____

Do you or does any member of your family (blood relative) have any of the following conditions?

Legend:

Ch=your child

M=mother

F=father

Br=brother

Si=sister

Mgm=maternal grandmother

Mgf=maternal grandfather

Pgm=paternal grandmother

Ma=maternal aunt

Mu=maternal uncle

Pa=paternal aunt

Pu=paternal uncle

Mfc=maternal first cousin

Pfc=paternal first cousin

S=self

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	Condition	Yes	NO	Specific Family Member
1.	Mental retardation			
2.	Learning disability			
3.	Hyperactivity			
4.	Down's Syndrome			
5.	Chromosomal disorder			
6.	Fragile X Syndrome			
7.	Hydrocephalus			
8.	Cleft Lip or Palate			
9.	Congenital Heart Defect (at birth)			

	Condition	Specific Family		
		Yes	NO	Member
10.	Open neural tube defect or anencephaly			
11.	Other spine deformity			
12.	Clubfoot			
13.	Dwarfism or short stature			
14.	Hip Dislocation			
15.	Extra or Missing Fingers or Toes			
16.	Other limb abnormalities			
17.	Allergies			
18.	Cystic fibrosis			
19.	Alpha-1-antitrypsin			
20.	Other lung disease			
21.	Cataracts before age 60 years			
22.	Blindness			
23.	Color blindness			
24.	Glaucoma before the age of 60 years			
25.	Retinitis pigmentosa			
26.	Deafness before the age of 60 years			
27.	Ear deformity			
28.	Pyloric stenosis			
29.	Ulcers			
30.	Ulcerative colitis			
31.	Crohn's disease			

	Condition	Yes	NO	Specific Family Member
32.	Other digestive problems			
33.	Liver disease			
34.	Polycystic kidney disease			
35.	Kidney abnormality			
36.	Muscular dystrophy			
37.	Multiple sclerosis			
38.	Cerebral palsy			
39.	Loss of muscle control			
40.	Other muscle disease			
41.	Sickle cell disease			
42.	Thalassemia			
43.	Hemophilia			
44.	Other blood or clotting disorders			
45.	PKU			
46.	You or family member on a special diet			
47.	Tay-Sachs disease			
48.	Inherited metabolic disorder			
49.	Eczema			
50.	Pigmentation disorder			
51.	Coffee colored spots on skin			
52.	Neurofibromatosis			
53.	Severe Depression			

	Condition	Yes	NO	Specific Family Member
54.	Manic depression or bipolar disorder			
55.	Schizophrenia			
56.	Other mental health problem			
57.	Alcoholism			
58.	Drug abuse			
59.	Migraines			
60.	Epilepsy or seizure disorder			
61.	Senility before the age of 60 years			
62.	Huntington's disease			
63.	Alzheimer's disease			
64.	Other disease of the nervous system			
65.	Diabetes			
66.	Thyroid disorder			
67.	High cholesterol			
68.	Heart attack before the age of 50 years			
69.	Heart disease in adulthood			
70.	Stroke before the age of 60 years			
71.	Colon cancer			
72.	Breast cancer			
73.	Cancer of the cervix, ovaries, or uterus			
74.	Skin Cancer			
75.	Other Cancers			

Condition		Yes	NO	Specific Family Member
76.	Infertility			
77.	Miscarriages			
78.	Stillborn or baby born dead			
79.	Infant or neonatal death			
80.	Genetic disorder or disease			
81.	Birth defect or handicap			
82.	Autism			
83.	Lupus, Arthritis, or Other Auto Immune Disorder			
84.	Other			

Have you ever been screened for a genetic disorder such as Tay Sachs, Sickle Cell, Thalassemia or Cystic Fibrosis? YES NO
 If yes, where was the test done and when?

Results: _____

Family History

	Age	Height	Weight	Hair Color	Eye Color	Medical Problems
Mother						
Grandmother						
Grandfather						
Father						
Grandmother						
Grandfather						
Brother/Sister						
Brother/Sister						
Brother/Sister						

I hereby certify that my answers and explanations, which were voluntarily given in this questionnaire, are correct to the best of my knowledge. I did not knowingly withhold any medical, psychological, and/or behavioral information on this questionnaire. I understand and agree that the information on this form, absent any response that would serve to positively identify me, will be provided to a recipient couple, who may wish to consider me as their donor. I consent to the disclosure of information contained in this form, to the extent that it does not identify me.

Signature

Date

Fax the completed questionnaire to Donna Ketchum at 410-328-0834.